State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to:

California Department of Health Services
Provider Enrollment Branch
Payment Systems Division
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

PLEASE NOTE: Effective January 1, 2004, new law governing enrollment of providers in the Medi-Cal program resulted in a process for the California Department of Health Services (CDHS) to more thoroughly review applicants applying to participate in the Medi-Cal program and established a new provisional provider status. In addition, it resulted in revisions to the provider enrollment application forms.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned. Due to the volume of applications received, program staff is unable to reply to a request for the status of an application in process. Therefore, please allow for the 180 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Information about the completion of enrollment forms is located on the Medi-Cal Web site at **www.medi-cal.ca.gov**.

Enrollment forms are available at **www.medi-cal.ca.gov** or by contacting the Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the “Provider Enrollment” link. If you have any questions, please submit your inquiry in writing to the above address

Provider Enrollment Branch
Payment Systems Division

Enclosures (Revised 3/06)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED/DENTAL PROVIDERS

DO NOT USE staples on this form or on any attachments.
DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date and initial in ink.
DO NOT LEAVE any question, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This form is part of an application for enrollment or continued enrollment as a rendering provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in a program. In addition to this form and requested documentation, a Medi-Cal Disclosure Statement (DHS 6207) and a Medi-Cal Provider Agreement (DHS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

Omission of any information on this form, or the failure to provide required documentation or sign any of these documents may result in denial of the application as provided in California Code of Regulations (CCR), Title 22, Section 51000.50.

To request consideration for Preferred Provider Status, check the box and include all required documentation pursuant to the Provider Bulletin dated February 2004 or go to the Medi-Cal web site, Provider Enrollment link to Preferred Provider Status. Only those complete applications submitted with all qualifying documentation included will be processed with a preferred provider status.

Action requested (check all that apply). Enter the date you are completing the application.

"New rendering physician/allied/dental provider"—the applicant is not currently enrolled with the Medi-Cal program and would like to have a Medi-Cal provider number issued.

Provider Type: Check the appropriate provider type box for which you are applying to render services for the Medi-Cal program.

1. "Legal name"—enter the name listed with the Internal Revenue Service (IRS).
2. Enter the date of birth of the individual named in number 1.
3. Enter the gender of the individual named in number 1.
4. "Residence address"—enter the residence address of the individual listed in number1.
5. Enter the social security number of the individual named in number 1. (This field is ***optional***—see Privacy Statement on page 5.)
6. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
7. Enter the license certificate number, or other permit or approval to provide health care, of the applicant. Attach a legible copy of the license, certificate, permit, or approval. Enter the effective date of the license certificate number, or other permit or approval. Enter the expiration date of the license certificate number, or other permit or approval. If a physician or dentist, list the specialty(ies) and indicate if board-certified or -eligible.
8. "Business address"—enter the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
9. "Business telephone number"—enter the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
10. "Contact person"—enter the name of the person who can be contacted regarding the application package.
11. "Contact telephone number"—enter the phone number of the contact person.
12. "Contact e-mail address"—enter the e-mail address of the contact person.
13. "Medi-Cal number of Group being joined"—enter the Medi-Cal number of the Medi-Cal Group Provider that the individual named in number 1 is joining.
14. "Proof of professional liability insurance"—enter the name of the insurance company, insurance policy number, date policy issued, expiration date of policy, insurance agent's name, telephone number of the insurance agent, fax number of the insurance agent and email address of the insurance agent. You must also attach a copy of your certificate of insurance to the application.

Disclosure Information

1. Check the appropriate boxes and provide the date of conviction if applicable.
2. Check the appropriate boxes and provide the date of final judgment of applicable.
3. Check the appropriate boxes and provide the date of settlement if applicable.
4. Check the appropriate box and list all Medi-Cal numbers, if appropriate, as well as the state(s) and name(s) applicant or provider used when participating in another state Medicaid program and all applicable provider numbers. If you cannot provide the numbers, please explain.
5. Check the appropriate box and, if applicable, provide the effective date(s) of suspension(s), date(s) of reinstatement, and Medi-Cal, Medicare and/or Medicaid provider number(s).
6. Check the appropriate box and, if applicable, list the state(s) where applicant's or provider's license, certificate, or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
7. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach a written confirmation from the licensing authority that professional privileges have been restored.
8. Check the appropriate box and, if applicable, list the requested information.
9. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid, and all other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). Submit copies of all documents pertaining to the arrangement(s) including terms and conditions. If not applicable, check N/A box.

Provider Agreement

Print name of the applicant signing the application. An original signature of the individual is required. Include the city, state, and the date where and when the application was signed.

✓ Remember to attach a legible copy of the following, if applicable:

- ☐ Driver's license or state-issued identification card
- ☐ License certificate
- ☐ Verification of reinstatement
- ☐ Written confirmation from licensing authority that your professional privileges have been restored.
- ☐ Copies of payment arrangement documents
- ☐ Notary Public Certificate of acknowledgement
- ☐ Certificate of insurance (malpractice)
- ☐ Drug Enforcement Agency (DEA) certificate
- ☐ Anesthesia Permit
- ☐ Conscious Sedation Permit

MEDI-CAL RENDERING PROVIDER APPLICATION/DISCLOSURE STATEMENT/AGREEMENT FOR PHYSICIAN/ALLIED/DENTAL PROVIDERS

FOR STATE USE ONLY

Important:
- Read all instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to: For Denti-Cal return completed forms to:

Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 323-1945

Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

☐ Preferred provider status requested pursuant to Welfare and Institutions Code Section 14043.26(c). All qualifying documentation and cover letter attached.

Do not use staples on this form or on any attachments.
Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check[✓] all that apply)
☐ New rendering physician/allied/dental provider

Date / /

Provider Type (check one)
☐ Audiologist ☐ Certified Nurse Midwife ☐ Certified Registered Nurse Anesthetist ☐ Chiropractor ☐ Dentist ☐ Optometrist ☐ Orthotist ☐ Physician ☐ Podiatrist ☐ Prosthetist ☐ Psychologist ☐ Registered Dental Hygienist Alternative Practice ☐ Other: _____

1. Legal name of applicant (last name) (first name) (middle name)
2. Date of birth / /
3. Gender

4. Residence address (number, street) City State Nine-digit ZIP code

5. Social security number
6. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

7. Professional license/certified certificate/permit number (attach legible copy)
License effective date / /
License expiration date / /
List specialty(ies)—Physicians and dentists only
Yes No
Board-certified ☐ ☐
Board-eligible ☐ ☐

8. Business address (office/hospital) (number, street) City County State Nine-digit ZIP code

9. Business telephone number ( )
10. Contact person's name
11. Contact person's telephone number ( )
12. Contact person's email address

13. Medi-Cal number of Group being Joined

14. Proof of Professional Liability Insurance-Applicant must attach a copy of their certificate of (malpractice) insurance to this application.

Name of Insurance company

Insurance policy number
Date policy issued (mm/dd/yyyy) / /
Expiration Date of policy (mm/dd/yyyy) / /

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number ( )
Fax number ( )
E-mail address

DISCLOSURE INFORMATION

Respond to the following questions:

1. ***Within ten years of the date of this statement***, have you, the applicant/provider, been convicted of any felony or misdemeanor involving fraud or abuse in any government program? ☐ Yes ☐ No
   If yes, provide the date of the conviction (mm/dd/yyyy): / /
2. ***Within ten years of the date of this statement,*** have you, the applicant/provider, been found liable for fraud or abuse involving a government program in any civil proceeding? ☐ Yes ☐ No
   If yes, provide the date of final judgment (mm/dd/yyyy): / /
3. ***Within ten years of the date of this statement,*** have you, the applicant/provider, entered into a settlement in lieu of conviction for fraud or abuse involving a government program? ☐ Yes ☐ No
   If yes, provide the date of the settlement (mm/dd/yyyy): / /

4. Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid program? ☐ Yes ☐ No

If yes, provide the following information:

STATE	NAME(S) (LEGAL AND DBA)	PROVIDER NUMBER(S)

5. Have you, the applicant/provider, ***ever*** been suspended from a Medicare, Medicaid, or Medi-Cal program? ☐ Yes ☐ No

If yes, attach verification of reinstatement and provide the following information:

CHECK APPLICABLE PROGRAM	PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE
☐ Medi-Cal ☐ Medicaid ☐ Medicare		/ / / / / /	/ / / / / /
☐ Medi-Cal ☐ Medicaid ☐ Medicare		/ / / / / /	/ / / / / /

6. Has the individual license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been suspended or revoked? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)
	/ /
	/ /

7. Have you, the applicant/provider, ***ever*** lost or surrendered your license, certificate, or other approval to provide health care while a disciplinary hearing was pending? ☐ Yes ☐ No

If yes, attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

WHERE ACTION(S) WAS TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)
	/ /
	/ /

8. Has the license, certificate, or other approval to provide health care of the applicant/provider ***ever*** been disciplined by any licensing authority? ☐ Yes ☐ No

WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)
		/ /
		/ /

9. List below fines/debts due and owing by applicant/provider to any federal, state, or local government that relate to Medicare, Medicaid and ***all*** other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). ***Submit copies of all documents*** pertaining to the arrangements including terms and conditions. See California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6). ☐ N/A

FINE/DEBT	AGENCY	DATE ISSUED	DATE TO BE PAID IN FULL
$		/ /	/ /
$		/ /	/ /

PROVIDER AGREEMENT

I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments is true, accurate, and complete to the best of my knowledge and belief.

I understand that the failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status and suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used to obtain reimbursement from the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Health Services ("DHS"), Provider Enrollment Branch.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual, including the requirements for record keeping and the disclosure of information. I understand that compliance with all Medi-Cal laws and regulations is a condition for participation as a provider in the Medi-Cal program.

I agree to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHS, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States Centers for Medicare and Medicaid Services. I further agree to provide if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program. Applicant/Provider will be reimbursed for reasonable copy costs as determined by DHS or AG.

I also agree that DHS and/or AG may make unannounced visits to Applicant/Provider, at any of Applicant's/Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHS or AG, or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program.

Printed legal name of applicant (last) (first) (middle)

Original signature of applicant

Executed at: _____ (City), _____ (State) on _____ (Date)

Notary Public:

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ***ARE NOT REQUIRED*** to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the California Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Branch, Payment Systems Division, Sacramento, CA, at (916) 323-1945, or contact Denti-Cal at (800) 423-0507.